

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11219

## CERTIFICATE OF DEATH

Reg. Dist. No.

11200

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural near - Calvert</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural near - Calvert</i>		
c. LENGTH OF STAY IN 1b <i>50 yrs</i>			d. STREET ADDRESS <i>1 1/4 mi. E. of Rising Sun</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Mary</i> Last <i>Barber</i>			4. DATE OF DEATH Month <i>Oct.</i> Day <i>31</i> Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/9/1864</i>		9. AGE (In years last birthday) <i>94</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Cecil Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Thomas Davis</i>			14. MOTHER'S MAIDEN NAME <i>Ratherine Lake</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerosis.</i> DUE TO (c) <i>Infected mouth &amp; legs.</i>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>9-20</i> , 19 <i>58</i> , to <i>10-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10-20</i> , 19 <i>58</i> , and that death occurred at <i>6:45</i> A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>R. C. Dodson, MD</i>		ADDRESS (Street, city or town, state) <i>Rising Sun, Md</i>		DATE SIGNED <i>10/31-58</i>	
PHYSICIAN'S NAME (Type) <i>R C DODSON, MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>11/3/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rose Bank</i>	22d. LOCATION (City, town, or county) <i>Calvert, Cecil Co., Md.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed, Rising Sun, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>
		DATE <i>NOV 2 1958</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11201

## 11220 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Cecil</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rising Sun, Rural</b>		LENGTH OF STAY (in this place) <b>6 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rising Sun, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Mary Ann Baxter</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 10 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 28, 1873</b>	9. AGE last birthday <b>85 84 yrs.</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jesse Burroughs</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 14- 7547D</b>		17. INFORMANT & ADDRESS <b>Mrs. Wm. R. Edmondson Rising Sun Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <b>Chronic Myocarditis</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>arteriosclerosis severe</b>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5-25-56</b> , 19....., to <b>10-8-58</b> , 19....., that I last saw the deceased alive on <b>10-8-</b> , 19 <b>58</b> ....., and that death occurred at <b>1.15 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>R. C. Edmondson</b>				ADDRESS (Street, city, town, state) <b>Rising Sun, Md.</b>		DATE SIGNED <b>10-11-58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Oct. 13 1958</b>		NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cem.</b>		LOCATION (City, town, or county) (State) <b>Rising Sun, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>		REGISTRAR'S SIGNATURE <i>Arthur S. House</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Earl Tyson</i> ADDRESS <b>Rising Sun Md.</b>			

1981

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11221

## CERTIFICATE OF DEATH

Reg. Dist. No.

11202

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>V. A. Hospital</b>				d. STREET ADDRESS <b>Darlington</b>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>(NMI)</b> Last <b>BIRTWISTLE</b>				4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-95</b>	9. AGE (In years last birthday) <b>63 years</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tourist Camp Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		11. BIRTHPLACE (State or foreign country) <b>Clifton Heights, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK BIRTWISTLE</b>				14. MOTHER'S MAIDEN NAME <b>PRESCILLA SUTTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>164-07-9264</b>		17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic glomerulonephritis.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>  <b>Unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-9-</b> <b>19 58</b> , to <b>10-25-</b> <b>19 58</b> , that I last saw the deceased alive on <b>10-25-58</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH., Perry Point, Maryland</b> DATE SIGNED <b>10-25-58</b>							
ACTUAL SIGNATURE <b>J. C. Grasperger, M.D.</b>		PHYSICIAN'S NAME (Type) <b>J. C. GRASBERGER, M.D. Acting Director, Professional Services.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10-28-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Centre Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forest Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>POSTER FUNERAL HOME, Bel Air, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 28 58</b>		24b. REGISTRAR'S SIGNATURE <b>James E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G234, 10/10/58 fcy

11222

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

11203

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>13 Barton Road, Manor Heights</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Stephen</b> Last <b>Bostwick</b>				4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 October/1958</b>	
9. AGE (In years lost birthday) yrs. <b>22</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Arthur Paul Bostwick</b>				14. MOTHER'S MAIDEN NAME <b>Mary Anne Lowry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Hospital Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x</b> <b>PREMATURITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 October</b> , 19 <b>58</b> , to <b>6 October</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 October</b> , 19 <b>58</b> , and that death occurred at <b>6:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bainbridge, Md.</b> DATE SIGNED <b>10/8/58</b>							
ACTUAL SIGNATURE <b>James K. Fugate</b>				M.D. <b>U. S. Naval Hospital, Bainbridge, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JAMES K. FUGATE, LT MC USNR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Coloma, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>PERRYVILLE, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 9 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

2151221XV2



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11204

11207

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>BRINKLEY</b> Last <b>BRINKLEY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1932</b>
9. AGE (In years last birthday) <b>26 2/3</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b>24</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Brinkley</b>	
14. MOTHER'S MAIDEN NAME <b>Addie Harmon</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Jan. 7, 53 Jan. 6, 55</b>	
16. SOCIAL SECURITY NO. <b>213-30-0016</b>		17. INFORMANT <b>Addie Brinkley,</b> Address <b>Cecilton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab Wound of Chest</b> 982x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed during altercation.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10/19 19 58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Cecilton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton, Colored Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Fellows</i>		24a. REC'D BY REGISTRAR <b>OCT 23 '58</b>	
ADDRESS <i>Wellington, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimes</i>	

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28. *Journal of the American Medical Association*, 279, 10, 1523-1524 (1997).

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11223

## CERTIFICATE OF DEATH

## 11205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising, Sun, Rural</b>				c. LENGTH OF STAY IN 1b <b>2 wks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Graybeal Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Matilda</b> First <b>Josephine</b> Middle <b>Chambers</b> Last				4. DATE OF DEATH <b>October</b> Month <b>28,</b> Day <b>1958</b> Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1885</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Louis Meyer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Magley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Ernest W. Chambers</b> Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO <b>33/X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebrovascular accident</b> DUE TO <b>3 wks.</b> (c) <b>3 days</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10/1</b> , 19 <b>58</b> , to <b>10/28</b> , 19 <b>58</b> that I last saw the deceased alive on <b>10/28</b> , 19 <b>58</b> , and that death occurred at <b>3 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Neil Taylor</b> M.D.				ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>10/28/58</b>			
PHYSICIAN'S NAME (Type) <b>Neil Taylor Jr</b>				ADDRESS <b>Rising Sun, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bertha - Minn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>				ADDRESS <b>Rising Sun, Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11208

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>Cokesbury</b>	
3. NAME OF DECEASED (Type or print) First <b>Infant</b> Middle <b>Clark</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>6</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hezekiah Clark</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Cain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hezekiah Clark, Port Deposit, Md. Rural</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity - 32 wks. gestation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 Oct</b> , 19 <b>58</b> , to <b>20 Oct</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>19 Oct</b> , 19 <b>58</b> , and that death occurred at <b>1 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Klaus H. Huchner</b>		DATE SIGNED <b>20 Oct '58</b>	
PHYSICIAN'S NAME (Type) <b>Klaus H. Huchner M.D.</b>		ADDRESS (Street, city or town, state) <b>North East, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL	22b. DATE THEREOF <b>Oct. 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Patterson &amp; Son</b>		24a. REC'D BY REGISTRAR <b>Perryville, Md.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11209

## CERTIFICATE OF DEATH

Reg. Dist. No.

11207

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>246 E. Main Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Perkins</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Perkins</u>				14. MOTHER'S MAIDEN NAME <u>Laura Maxwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-36-3883</u>		17. INFORMANT <u>J. Charles Davis</u> Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>June 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Oct. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 6</u> , 19 <u>58</u> , and that death occurred at <u>12:38</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>Oct 6, 1958</u> ACTUAL SIGNATURE <u>Dr. Fred H. Spraker</u> M.D. PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

CERTIFICATE OF DEATH

11507

11507

Page One of Two

1. NAME OF DECEASED <b>JOHN J. SMITH</b>		2. SEX <b>MALE</b>		3. AGE <b>65</b>		4. RACE <b>WHITE</b>	
5. DATE OF BIRTH <b>1912-03-15</b>		6. PLACE OF BIRTH <b>NEW YORK, N.Y.</b>		7. DATE OF DEATH <b>1977-08-10</b>		8. PLACE OF DEATH <b>HOSPITAL</b>	
9. CAUSE OF DEATH <b>HEART DISEASE</b>		10. MANNER OF DEATH <b>NATURAL</b>		11. SIGNATURE OF PHYSICIAN <b>J. J. SMITH</b>		12. SIGNATURE OF REGISTRAR <b>J. J. SMITH</b>	
13. SIGNATURE OF DECEASED <b>J. J. SMITH</b>		14. SIGNATURE OF NEXT OF KIN <b>J. J. SMITH</b>		15. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		16. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
17. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		18. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		19. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		20. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
21. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		22. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		23. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		24. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
25. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		26. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		27. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		28. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
29. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		30. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		31. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		32. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
33. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		34. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		35. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		36. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
37. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		38. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		39. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		40. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
41. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		42. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		43. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		44. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
45. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		46. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		47. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		48. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
49. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		50. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		51. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		52. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
53. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		54. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		55. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		56. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
57. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		58. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		59. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		60. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
61. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		62. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		63. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		64. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
65. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		66. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		67. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		68. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
69. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		70. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		71. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		72. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
73. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		74. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		75. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		76. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
77. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		78. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		79. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		80. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
81. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		82. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		83. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		84. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
85. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		86. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		87. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		88. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
89. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		90. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		91. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		92. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
93. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		94. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		95. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		96. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	
97. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		98. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		99. SIGNATURE OF WITNESS <b>J. J. SMITH</b>		100. SIGNATURE OF WITNESS <b>J. J. SMITH</b>	

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11208

11224

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Cecil</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Perryville, Rural</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Perryville</b>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U. S. Route #7</b>							
3. NAME OF DECEASED (First) (Middle) (Last) <b>Walter Washington Gillespie</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>10 1 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Oct. 2, 1901</b>		9. AGE last birthday <b>56</b> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Alonzo R. Gillespie</b>				14. MOTHER'S MAIDEN NAME <b>Mary Geiser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-7770</b>		17. INFORMANT & ADDRESS <b>Mrs. C. B. Sturgill, Perryville, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) DUE TO (C)				Coronary Thrombosis, Recurrent Arteriosclerotic Cardiovascular Disease Interval between onset and death <b>Sudden 24 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec 13th 1958</b> , to <b>Oct 1st 1958</b> , that I last saw the deceased alive on <b>Oct 1st 1958</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Walter C. Chason</b>				ADDRESS (Street, city, town, state) <b>M. D. Haverdopace Ind. Oct 2nd 1958 at 11 P.</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>10/4/58</b>		NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. REC'D BY REGISTRAR <b>OCT 6 58</b>		REGISTRAR'S SIGNATURE <b>Arthur S. Lewis</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter C. Chason &amp; Son, Perryville, Md</b>			
DATE							

11308

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

## CERTIFICATE OF DEATH

11308

Date of Death

1. Usual Residence (Home or Hotel)

2. Place of Death

3. Cause of Death

4. Date of Death

5. Place of Burial

6. Date of Burial

7. Age

8. Sex

9. Race

10. Marital Status

11. Date of Birth

12. Date of Death

13. Date of Burial

14. Date of Death

15. Date of Burial

16. Date of Death

17. Date of Burial

18. Date of Death

19. Date of Burial

20. Date of Death

21. Date of Burial

22. Date of Death

23. Date of Burial

24. Date of Death

25. Date of Burial

26. Date of Death

27. Date of Burial

28. Date of Death

29. Date of Burial

30. Date of Death

31. Date of Burial

32. Date of Death

33. Date of Burial

34. Date of Death

35. Date of Burial

36. Date of Death

37. Date of Burial

2001-2002

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11225 CERTIFICATE OF DEATH

11209

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Cecil</b>		STATE <b>Md.</b>		COUNTY <b>Cecil</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		LENGTH OF STAY (Up this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>S. Main</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Samuel Hasson</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>10 11 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State) <b>Single</b>	8. DATE OF BIRTH <b>12-7- 1870</b>	9. AGE last birthday <b>87</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S V Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Abraham Hasson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Kelley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Norman Hasson, Port Deposit, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A)				<b>Cerebral Sclerosis -</b>		<b>3 months</b>	
ANTECEDENT CAUSE(S) DUE TO				<b>Arterio Sclerosis</b>		<b>8 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<b>Chronic Myocarditis</b>		<b>5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 5, 1958</b> , to <b>Oct. 10, 1958</b> , that I last saw the deceased alive on <b>Oct. 10, 1958</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Clarence J. Brown</b> M.D.				ADDRESS (Street, city, town, state) <b>Port Deposit, Md.</b>		DATE SIGNED <b>10-17-58</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>10-14-1958</b>		NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>		REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Nee a. Patterson &amp; Son, Perryville, Md.</b>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

11210

Reg. Dist. No. ....

11226

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Cecil</b>		STATE <b>Md.</b>		COUNTY <b>Cecil</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Port Deposit, Rural</b>		LENGTH OF STAY (In this place) <b>1 Month</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Perryville, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cokesbury</b>				STREET ADDRESS (If rural give location) <b>/</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>William Henry Hawkins</b>				<b>4. DATE OF DEATH</b> (Month) <b>Oct.</b> (Day) <b>12</b> (Year) <b>1958</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>11-18-1882</b>		<b>9. AGE last birthday</b> <b>75</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Hawkins</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Hill</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>John Hill, Havre De Grace, Md. R D 1</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
422.2 IMMEDIATE CAUSE (A) <b>Chronic Nephritis</b>						<b>2 yrs -</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Oct 11, 1958, to Oct 11, 1958, that I last saw the deceased alive on Oct 11, 1958, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Clarence J. Benson</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Port Deposit, Md.</i>		<b>DATE SIGNED</b> <i>10/13/58</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>10-15-1958</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Stewartville Cem.</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Havre De Grace, Md. R.D. 1</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Clarence J. Benson</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wesley Patterson</i>		<b>ADDRESS</b> <b>Perryville, Md.</b>	
<b>DATE</b> <b>OCT 14 '58</b>							

# DEATH CERTIFICATE

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It is to be filed in the office of the Registrar of Vital Statistics, and a copy is to be sent to the County Clerk of the County in which the deceased resided at the time of death. The date of death must be given in full, including the day, month, and year. The cause of death must be given in full, including the immediate cause, the intermediate cause, and the remote cause. The place of death must be given in full, including the street, city, county, and State. The name of the deceased must be given in full, including the first name, middle name, and last name. The date of birth must be given in full, including the day, month, and year. The sex of the deceased must be given. The race of the deceased must be given. The marital status of the deceased must be given. The occupation of the deceased must be given. The signature of the physician or other qualified person must be given. The signature of the Registrar of Vital Statistics must be given. The signature of the County Clerk must be given.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

11310

11310

DEATH CERTIFICATE

1. NAME OF DECEASED

JOHN

MR.

BUTLER

Perryville, Md.

11-18-1938

11-18-1938

Wednesday

Hawkins

Henry

William

John

11-18-1938

11-18-1938

11-18-1938

11-18-1938

MD.

MD.

MD.

Will

Butler

Hawkins

John

John Will Butler, No. 11-18-1938

11-18-1938

11-18-1938

11-18-1938

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11-18-1938

11-18-1938

11-18-1938

10-18-1938 Perryville, Md. No. 11-18-1938

Perryville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

## CERTIFICATE OF DEATH

Reg. Dist. No.

11211

1. PLACE OF DEATH a. COUNTY <u>Sevier</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Sevier-Md</u> b. COUNTY <u>Sevier</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2-1 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 168 St. Main St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry Metz Hewlow</u> (HEVLOW)		4. DATE OF DEATH <u>October 17</u> 19 <u>55</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20-1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Reuben Hewlow</u>		14. MOTHER'S MAIDEN NAME <u>Clarence Metz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-01-5079</u>	
17. INFORMANT <u>Mr. Harry Hewlow</u> Address <u>168 St. Main St Elkton-Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> <u>unknown</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14-16</u> , 19 <u>55</u> , to <u>Oct 17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Oct 14-16</u> , 19 <u>55</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. H. McKnight</u> M.D.		ADDRESS (Street, city or town, state) <u>Elkton Maryland</u> DATE SIGNED <u>Oct 21 '58</u>	
PHYSICIAN'S NAME (Type) <u>V. H. McKnight</u>		<u>Elkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 20, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Small M. Bee</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>                    </u> 24b. REGISTRAR'S SIGNATURE <u>                    </u>	

CERTIFICATE OF DEATH

11310

11311

PLACE IN CASE OF 1. DEATH		2. MANNER OF DEATH		3. CAUSE OF DEATH	
A. DEATH		B. MANNER OF DEATH		C. CAUSE OF DEATH	
1. DEATH		2. MANNER OF DEATH		3. CAUSE OF DEATH	
4. DEATH		5. MANNER OF DEATH		6. CAUSE OF DEATH	
7. DEATH		8. MANNER OF DEATH		9. CAUSE OF DEATH	
10. DEATH		11. MANNER OF DEATH		12. CAUSE OF DEATH	
13. DEATH		14. MANNER OF DEATH		15. CAUSE OF DEATH	
16. DEATH		17. MANNER OF DEATH		18. CAUSE OF DEATH	
19. DEATH		20. MANNER OF DEATH		21. CAUSE OF DEATH	
22. DEATH		23. MANNER OF DEATH		24. CAUSE OF DEATH	
25. DEATH		26. MANNER OF DEATH		27. CAUSE OF DEATH	
28. DEATH		29. MANNER OF DEATH		30. CAUSE OF DEATH	
31. DEATH		32. MANNER OF DEATH		33. CAUSE OF DEATH	
34. DEATH		35. MANNER OF DEATH		36. CAUSE OF DEATH	
37. DEATH		38. MANNER OF DEATH		39. CAUSE OF DEATH	
40. DEATH		41. MANNER OF DEATH		42. CAUSE OF DEATH	
43. DEATH		44. MANNER OF DEATH		45. CAUSE OF DEATH	
46. DEATH		47. MANNER OF DEATH		48. CAUSE OF DEATH	
49. DEATH		50. MANNER OF DEATH		51. CAUSE OF DEATH	
52. DEATH		53. MANNER OF DEATH		54. CAUSE OF DEATH	
55. DEATH		56. MANNER OF DEATH		57. CAUSE OF DEATH	
58. DEATH		59. MANNER OF DEATH		60. CAUSE OF DEATH	
61. DEATH		62. MANNER OF DEATH		63. CAUSE OF DEATH	
64. DEATH		65. MANNER OF DEATH		66. CAUSE OF DEATH	
67. DEATH		68. MANNER OF DEATH		69. CAUSE OF DEATH	
70. DEATH		71. MANNER OF DEATH		72. CAUSE OF DEATH	
73. DEATH		74. MANNER OF DEATH		75. CAUSE OF DEATH	
76. DEATH		77. MANNER OF DEATH		78. CAUSE OF DEATH	
79. DEATH		80. MANNER OF DEATH		81. CAUSE OF DEATH	
82. DEATH		83. MANNER OF DEATH		84. CAUSE OF DEATH	
85. DEATH		86. MANNER OF DEATH		87. CAUSE OF DEATH	
88. DEATH		89. MANNER OF DEATH		90. CAUSE OF DEATH	
91. DEATH		92. MANNER OF DEATH		93. CAUSE OF DEATH	
94. DEATH		95. MANNER OF DEATH		96. CAUSE OF DEATH	
97. DEATH		98. MANNER OF DEATH		99. CAUSE OF DEATH	
100. DEATH		101. MANNER OF DEATH		102. CAUSE OF DEATH	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BURLINGAME 10

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BURLINGAME 10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 18&21 Film 375 10-29-58  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11212  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b LIFG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS Route 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT RAY HITCHCOCK			4. DATE OF DEATH Month Day Year October 5 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1958		9. AGE (In years last birthday) yrs. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Elkton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Herbert J. Hitchcock			14. MOTHER'S MAIDEN NAME Carolina Rae Crouse		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Herbert J. Hitchcock Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Bronchopneumonia, probably secondary to aspiration of milk DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/6/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
22d. LOCATION (City, town, or county) Elkton, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Donald M. Pippin, Md.		24a. REC'D BY REGISTRAR DATE OCT 8 '58	
24b. REGISTRAR'S SIGNATURE					

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BURLINGAME 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11213

Reg. Dist. No.

11227

Item 4 Film 235 10-21-58 et

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Elkton, Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Paxson Kirk</u>		4. DATE OF DEATH Month Day Year <u>October 13, 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel M. Kirk</u>	
14. MOTHER'S MAIDEN NAME <u>Victoria Paxson Biles</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>220-34-6056</u>		17. INFORMANT Address <u>Mrs. Anna Stewart Kirk, Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Myocarditis</u> (c) <u>DUE TO</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>Elkton, Cecil Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		DATE SIGNED <u>10-14-58</u>	
EXAMINER'S NAME (Type) <u>R.C. Dodson, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>	22d. LOCATION (City, town, or county) (State) <u>Calvert, Cecil Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph O. Brant North East Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>



11228

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x-3</b>			
d. STREET ADDRESS <b>2722 - 26th Street, N.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>E.</b> Last <b>LAY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-1-1878</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engraver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Photo</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James O. Lay</b>				14. MOTHER'S MAIDEN NAME <b>Louise Bower</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>S.A.W. 578-10-2427</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>5420</b> IMMEDIATE CAUSE (a) <b>Peritonitis localized, due to extravasated contents of viscera, post-operative Gastrojejunostomy for bleeding ulcer 10-4-58</b> DUE TO (b) <b>Gastrojejunostomy for bleeding ulcer 10-4-58</b> DUE TO (c) <b>Arteriosclerosis, general, severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general, severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>VA</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 4, 1958, to October 14, 1958, that he last saw the deceased alive on <b>19-10-58</b> and that death occurred at <b>4:45 a.m.</b> from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>10-14-58</b>							
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md.</b>							
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b> Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10/17/58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley Fun. Home, 3200 R.I. Ave. Mt. Rainier, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 17 58</b>			
24b. REGISTRAR'S SIGNATURE <b>Christ S. M...</b>							

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LAST NAME		FIRST NAME		MIDDLE NAME	
SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE	
OCCUPATION		EDUCATION		RELIGION	
MARRIED		SINGLE		WIDOW	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
FAMILY NAME		MIDDLE NAME		FIRST NAME	
SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE	
OCCUPATION		EDUCATION		RELIGION	
MARRIED		SINGLE		WIDOW	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11215

11229

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>/ 1152 Avenue A</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>LEITHISER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-99</u>	
9. AGE (In years last birthday) yrs. <u>59</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Havre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Leithiser</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Bayard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records, V.A. Hospital, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, left lower lobe unresolved</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Transverse myelitis level of thoracic 1</u> DUE TO <u>organism unknown</u> (c) <u>Multiple abscesses level of C-7 and T-1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis of the spine, severe - unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-5 days</u> <u>4-6 weeks</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>October 15, 1958</u> , to <u>October 16, 1958</u> , that I saw the deceased alive on <u>October 15, 1958</u> , and that death occurred at <u>7:55 a. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>10-16-58</u>							
ACTUAL SIGNATURE <u>S. P. LACERVA</u> M.D.				PHYSICIAN'S NAME (Type) <u>S. P. LACERVA</u> Director, Professional Services			
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington &amp; Son</u>				ADDRESS <u>Havre de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

PERMANENT CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

NAME OF PHYSICIAN: [illegible]

NAME OF NURSE: [illegible]

NAME OF ASSISTANT: [illegible]

NAME OF ATTENDING PHYSICIAN: [illegible]

NAME OF ASSISTANT PHYSICIAN: [illegible]

NAME OF ASSISTANT NURSE: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

NAME OF ASSISTANT ASSISTANT: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11230

## CERTIFICATE OF DEATH

## 11216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2yrs.2mos.20days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1024 Olive Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>LLOYD Jr.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>McCambridge Chemical Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Chesapeake City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM LLOYD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH LEIBOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe, unresolved.</b> DUE TO (b) <b>Chronic Brain Disease</b> DUE TO (c) <b>Cerebral arteriosclerosis, severe</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 to 3 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 12, 19 56</b> to <b>October 2, 19 58</b> , and that death occurred at <b>8:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>W. M. Harris</b> M.D.			
PHYSICIAN'S NAME (Type) <b>W. M. HARRIS, M.D., Acting Director, Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-7-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. COOK, Inc.,</b>		24a. REC'D BY REGISTRAR <b>St. Paul &amp; Preston Ave. Baltimore 6, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>		DATE <b>OCT 6 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

11212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Jane Last Mathis		4. DATE OF DEATH Month 10 Day 14 Year 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22- 1892
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. Buchanan		14. MOTHER'S MAIDEN NAME Sarah L. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 160-01-6973	
17. INFORMANT Charles S. Mathis		Address Port Deposit Route 3 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion with myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 Oct 1958, to 14 Oct 1958, that I last saw the deceased alive on 14 Oct 1958, and that death occurred at 7:35 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huchner M.D.		ADDRESS (Street, city or town, state) No. 14 East Rd DATE SIGNED 14 Oct 1958	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-18-1958	22c. NAME OF CEMETERY OR CREMATORY West Nottingham Presby	22d. LOCATION (City, town, or county) (State) Rising Sun Rural Cecil Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant North East, Maryland		24a. REC'D BY REGISTRAR DATE OCT 20 '58	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

11212

Page Two

PLACE OF DEATH HOME		MARRIAGE YES	
1. FULL NAME OF DECEASED JOHN DOE		2. DATE OF DEATH JAN 1 1900	
3. SEX MALE		4. AGE 45	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. PLACE OF BIRTH BALTIMORE, MD		8. DATE OF BIRTH DEC 15 1854	
9. NAME OF MOTHER JANE DOE		10. NAME OF FATHER JOHN DOE	
11. NAME OF SPOUSE MARY DOE		12. DATE OF MARRIAGE MAR 1 1880	
13. NAME OF PREVIOUS SPOUSE NONE		14. DATE OF PREVIOUS MARRIAGE NONE	
15. NAME OF PREVIOUS SPOUSE NONE		16. DATE OF PREVIOUS MARRIAGE NONE	
17. NAME OF PREVIOUS SPOUSE NONE		18. DATE OF PREVIOUS MARRIAGE NONE	
19. NAME OF PREVIOUS SPOUSE NONE		20. DATE OF PREVIOUS MARRIAGE NONE	
21. NAME OF PREVIOUS SPOUSE NONE		22. DATE OF PREVIOUS MARRIAGE NONE	
23. NAME OF PREVIOUS SPOUSE NONE		24. DATE OF PREVIOUS MARRIAGE NONE	
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95. NAME OF PREVIOUS SPOUSE NONE		96. DATE OF PREVIOUS MARRIAGE NONE	
97. NAME OF PREVIOUS SPOUSE NONE		98. DATE OF PREVIOUS MARRIAGE NONE	
99. NAME OF PREVIOUS SPOUSE NONE		100. DATE OF PREVIOUS MARRIAGE NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218

11231

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Freeman Morgan</u>		4. DATE OF DEATH Month Day Year <u>October 6, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 6, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Corp of Engineers</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Freeman</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Rebecca M. Davitt, Baltimore 18, Md</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Oct 5</u> , 19 <u>58</u> , to <u>Oct 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> P.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Wallace Oberstein</u>	DATE SIGNED <u>7 Oct 58</u>
PHYSICIAN'S NAME (Type) <u>Cecilton, Md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bethel, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR <u>Elkton, Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

# CERTIFICATE OF DEATH

11537

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>1. NAME OF DECEASED                  [Name of deceased]</p>		<p>2. SEX                  [Sex]</p>	
<p>3. AGE                  [Age]</p>		<p>4. DATE OF BIRTH                  [Date of birth]</p>	
<p>5. PLACE OF BIRTH                  [Place of birth]</p>		<p>6. OCCUPATION                  [Occupation]</p>	
<p>7. MARITAL STATUS                  [Marital status]</p>		<p>8. DATE OF MARRIAGE                  [Date of marriage]</p>	
<p>9. DATE OF DEATH                  [Date of death]</p>		<p>10. TIME OF DEATH                  [Time of death]</p>	
<p>11. PLACE OF DEATH                  [Place of death]</p>		<p>12. CAUSE OF DEATH                  [Cause of death]</p>	
<p>13. MEDICAL HISTORY                  [Medical history]</p>		<p>14. SURVIVAL                  [Survival]</p>	
<p>15. SIGNATURE OF PHYSICIAN                  [Signature of physician]</p>		<p>16. SIGNATURE OF REGISTRAR                  [Signature of registrar]</p>	
<p>17. SIGNATURE OF WITNESS                  [Signature of witness]</p>		<p>18. SIGNATURE OF DECEASED                  [Signature of deceased]</p>	

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. N. 11219

11232

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kyoet Corner		c. LENGTH OF STAY IN lb 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake City, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kyoet Corner	
3. NAME OF DECEASED (Type or print) Benjamin Nuble		f. STREET ADDRESS Chesapeake City, Md.	
4. DATE OF DEATH Month 10 Day 12 Year 19 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11- 1880
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Nuble		14. MOTHER'S MAIDEN NAME Mary A. Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ben. Nuble, Chesapeake City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-12-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/58	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. R. Bell Wilm. Del.		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NO. 12345678

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. OCCUPATION Carpenter	
5. PLACE OF BIRTH New York, N.Y.		6. DATE OF BIRTH Jan 15, 1900	
7. PLACE OF DEATH Boston, Mass.		8. DATE OF DEATH Jan 20, 1945	
9. CAUSE OF DEATH Myocardial Infarction		10. MANNER OF DEATH Natural	
11. SIGNATURE OF EXAMINER [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF CORONER [Signature]	
15. SIGNATURE OF JURY [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF JURY [Signature]		18. SIGNATURE OF JURY [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JURY [Signature]	
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99. SIGNATURE OF JURY [Signature]		100. SIGNATURE OF JURY [Signature]	

11213

## CERTIFICATE OF DEATH

11220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hosp.</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Raison</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1958</b>
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>u.s.a.</b>	
13. FATHER'S NAME <b>Raymond Raison</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mae Garnet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Raymond Raison</b>		Address <b>Chesapeake City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alcoholism</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory paralysis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>40 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 12, 1958</b> to <b>Oct 12, 1958</b> , that I last saw the deceased alive on <b>Oct 12, 1958</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Davis MD</b>		DATE SIGNED <b>10/2/58</b>	
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS MD</b>		ADDRESS (Street, city or town, state) <b>Chesapeake City, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 15, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bohemia Manor</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Chesapeake City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Oct 17 '58</b>	
ADDRESS <b>Ind. Du. Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>John P. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065223XV5

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 19, 1928		Memphis, Tennessee	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
April 4, 1968		Memphis, Tennessee		Heart Disease		Natural		None		High School	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
WEIGHT		HEIGHT		BLOOD PRESSURE		SUGAR		URIC ACID		BILIRUBIN	
170 lbs		5' 10"		120/80		100		5.0		0.2	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF MENTAL ILLNESS		HISTORY OF SUBSTANCE ABUSE		HISTORY OF TRAUMA	
None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF DECEASED		DATE	
[Signature]		April 4, 1968		[Signature]		April 4, 1968		[Signature]		April 4, 1968	

7

THIS CERTIFICATE IS VALID FOR 10 YEARS FROM THE DATE OF DEATH. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE RECORDS OF DEATHS IN THIS STATE. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED BY THE PHYSICIAN OR WITNESS. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED BY THE DECEASED. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED BY THE FAMILY.

11233

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Hartford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>			c. LENGTH OF STAY IN 1b <b>21 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre De Grace</b> 1224.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>556 Franklin Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>E.</b>		Middle <b>SARVER</b>		4. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-11</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Bastin, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK M. SARVER</b>				14. MOTHER'S MAIDEN NAME <b>LILLY STEELE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1 517 09 1676</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO <b>199.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma, adenocarcinoma, metastatic to lungs, mediastinal lymph nodes, &amp; abdominal lymph nodes. Origin obscure.</b> (c) <b>Over 1 1/2 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 To 5 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-21-</b> 19 <b>58</b> , to <b>10-12-</b> 19 <b>58</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>E. S. ELLS</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b> <b>10-12-58</b>					
PHYSICIAN'S NAME (Type) <b>E.S. ELLS, M.D., Acting Director, Professional Services</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>10-13-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Bastian, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 17 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Turner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

11333

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11214

CERTIFICATE OF DEATH

11222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Billy Boy</u> Middle <u>Sheets</u> Last <u></u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 22, 1958</u>
9. AGE (In years last birthday) yrs. <u>90</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Roger Sheets, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Callie Estridge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Roger Sheets, Sr.</u>		Address <u>R.D. #1 Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>90 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 27, 1958</u> to <u>Oct. 27, 1958</u> , that I last saw the deceased alive on <u>Oct. 27, 1958</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>Dr. J. H. Spracher</u> M.D.		PHYSICIAN'S NAME (Type) <u>Elkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bilpin Manor Memorial PK.</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. #1 Elkton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Pippin Funeral Home</u>		24a. REC'D BY REGISTRAR <u>W. A. Lusby</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	
DATE <u>OCT 29 '58</u>			

2065223XV0



11215

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Charles Shivery				4. DATE OF DEATH Month 10 Day 13 Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1911	9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer Sparklers				10b. KIND OF BUSINESS OR INDUSTRY Fireworks		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Harry Shivery				14. MOTHER'S MAIDEN NAME Adelaide Dick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-01-4591		17. INFORMANT Mrs Irene Reid Shivery Perryville, RD Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 592X DUE TO (b) Uremia DUE TO (c) Chronic interstitial nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 30 mints 24 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Bronch. Asthma c. Emphysema, Duodenal Ulcer, Cardiac Decompens.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-12-1958, to 10-13-1958, that I last saw the deceased alive on 10-12-1958, and that death occurred at 1:25 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Ave. North East, Md. DATE SIGNED 10-13-58							
ACTUAL SIGNATURE Luis M. Cuza, M.D.				PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-1958		22c. NAME OF CEMETERY OR CREMATORY St Mary Ann		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE OCT 16 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11224

11216

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.		c. LENGTH OF STAY IN 1b 30 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mae C. Smith		4. DATE OF DEATH Month Day Year October 14, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Thompson		14. MOTHER'S MAIDEN NAME Elizabeth Moran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Pauline R. Smith Wilm, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20, 1958, to Oct. 14, 1958, that I last saw the deceased alive on Oct. 14, 1958, and that death occurred at 2:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		DATE SIGNED 10/15/58	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home Donald M. Pippin		24a. REC'D BY REGISTRAR OCT 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneel			

no. 343

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6236 11-20-58 et

11217

CERTIFICATE OF DEATH

11225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Haven Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH R STEPHENS</b>				4. DATE OF DEATH <b>OCT 26 1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 10, 1863</b>	
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>RISING SUN, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRESS MAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>JOSEPH L. STEPHENS</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Rutledge</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs Edwin Haines, Rising Sun, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe generalized rheumatoid arthritis</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH							
21. I certify that I attended the deceased from <b>Feb. 10 1957</b> to <b>October 26 1958</b> , that I last saw the deceased alive on <b>Oct. 24 1958</b> , and that death occurred at <b>1:40a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>233 E. Main Street</b> DATE SIGNED <b>October 26, 1958</b> ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b> <b>Elkton, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/29/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE BANK</b>		22d. LOCATION (City, town, or county) (State) <b>CALVERT MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed</b> ADDRESS <b>Rising Sun Md</b>				24a. REC'D BY REGISTRAR <b>OCT 28 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

CERTIFICATE OF DEATH

1-1-15

STATE OF MARYLAND  
COUNTY OF BALTIMORE  
CITY OF BALTIMORE  
DEPARTMENT OF HEALTH  
OFFICE OF THE REGISTRAR  
BALTIMORE, MARYLAND

DATE OF DEATH: 1-1-15  
PLACE OF DEATH: 1-1-15  
AGE: 1-1-15  
SEX: 1-1-15  
RACE: 1-1-15  
MARRIAGE: 1-1-15  
OCCUPATION: 1-1-15  
EDUCATION: 1-1-15  
RELIGION: 1-1-15  
CAUSE OF DEATH: 1-1-15  
MANNER OF DEATH: 1-1-15  
SIGNATURE: 1-1-15  
DATE: 1-1-15

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218

CERTIFICATE OF DEATH

Reg. Dist. No.

11226

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1102 DECKER ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY WESSEL</u>		4. DATE OF DEATH Month Day Year <u>OCT. 14 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 25-1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FIREWORKS PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. H. Wessel</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN BLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-208684</u>	
17. INFORMANT <u>Perry Wessel</u>		Address <u>CHESTERTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 26, 1958</u> , to <u>Oct. 14, 1958</u> , that I last saw the deceased alive on <u>Oct. 14, 1958</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>		DATE SIGNED <u>Oct. 14, 1958</u>	
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 17</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>	22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hand</u>	

